

APPENDIX C – PROPOSAL FORMS

SPO-H-200

PROPOSAL LETTER

DISCLOSURE STATEMENT

FINANCIAL REPORTING/PLANNING

CONTROLLING INTEREST

BACKGROUND CHECK INFORMATION

OPERATIONAL CERTIFICATION SUBMISSION

GRIEVANCE SYSTEM

INSURANCE REQUIREMENTS

WAGE CERTIFICATION

PROVIDER STANDARDS OF CONDUCT

STATE OF HAWAII
STATE PROCUREMENT OFFICE
PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: _____

RFP NUMBER: _____

RFP TITLE: _____

Check one:

☐ Initial Proposal Application

☐ Final Revised Proposal (Completed Items _____ - _____ only)

1. APPLICANT INFORMATION

Legal Name: _____

Doing Business As: _____

Street Address: _____

Mailing Address: _____

Contact person for matters involving this application:
Name: _____

Title: _____

Phone Number: _____

Fax Number: _____

e-mail: _____

2. BUSINESS INFORMATION

Type of Business Entity (*check one*):

☐ Non-Profit Corporation

☐ Limited Liability Company

☐ Sole Proprietorship

☐ For-Profit Corporation

☐ Partnership

If applicable, state of incorporation and date incorporated:

State: _____

Date: _____

3. PROPOSAL INFORMATION

Geographic area(s): _____

Target group(s): _____

4. FUNDING REQUEST

FY _____

FY _____

FY _____

FY _____

FY _____

FY _____

Grand Total _____

I certify that the information provided above is to the best of my knowledge true and correct.

Authorized Representative Signature

Date Signed

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals for medical services. The administrative rates offered herein shall apply for the period of time stated in said RFP.

It is understood that this proposal constitutes an offer and when signed by the authorized State of Hawaii official will, with the RFP and any amendments thereto, constitute a valid and legal contract between the undersigned applicant and the State of Hawaii.

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications.

We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications unless proposal is withdrawn in accordance with Section 80.700.

Authorized
Date

Applicant's

Signature/Corporate

Seal

**CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE
AGREEMENTS**

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.
3. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for such failure.

Applicant: _____
Signature: _____
Title: _____
Date: _____

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the applicant fails to disclose ownership or controlling information and related party transaction as required by this policy.

- a) Disclosures in accordance with 42 CFR 455 Subpart B
§ 455.104

Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1) (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) When the disclosures must be provided.

(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

- (i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
- (ii) Upon the managed care entity executing the contract with the State.
- (iii) Upon renewal or extension of the contract.
- (iv) Within 35 days after any change in ownership of the managed care entity.
- (d) To whom must the disclosures be provided.** All disclosures must be provided to the Medicaid agency.
- (e) Consequences for failure to provide required disclosures.** Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

§ 455.105

Disclosure by providers: Information related to business transactions.

- (a) Provider agreements.** A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.
- (b) Information that must be submitted.** A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—
 - (1)** The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
 - (2)** Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
- (c) Denial of Federal financial participation (FFP).** **(1)** FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
- (2)** FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

§ 455.106

Disclosure by providers: Information on persons convicted of crimes.

- (a) Information that must be disclosed.** Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:
 - (1)** Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
 - (2)** Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.
- (b) Notification to Inspector General.** **(1)** The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.
- (2)** The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.
- (c) Denial or termination of provider participation.** **(1)** The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

b) Additional information which must be disclosed to DHS is as follows:

- 1) Names and addresses of the Board of Directors of the disclosing entity.
- 2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.
- 3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

- 1) Describe transactions between the disclosing entity and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of \$10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.
- 2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.
- 3) As used in this section, "related party" means one that has the power to control or significantly influence the applicant, or one that is controlled or significantly influenced by the applicant. "Related parties" include, but are not limited to agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

§ 455.101

Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information

because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- (a)** Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- (b)** Any Medicare intermediary or carrier; and
- (c)** Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

- (a)** Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b)** Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c)** Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- (d)** Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e)** Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f)** Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

- (a)** An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—

(1) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

DISCLOSURE STATEMENT

Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the applicant's ability to meet Dental TPA objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected *in* the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties may be in the normal course of business or they may represent something unusual for the applicant. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

1) Describe transactions between the applicant and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of \$10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact on the fiscal soundness of the disclosing entity.

a) The sale or exchange, or leasing of any property:

Description of Transaction(s)

Name of Related Party
and Relationship

Dollar Amount for Reporting Period

Justification

2. Describe all transactions between the disclosing entity *and* any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

Description of Transaction(s)

Name of Related Party
and Relationship

Dollar Amount for Reporting
Period

Justification

DISCLOSURE STATEMENT

Provider NAME/NO. _____

DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

I hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Provider, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in Dental TPA Services.

Date Signed

Chief Executive Officer (Name and Title
Typewritten)

Notarized

Signature

**DISCLOSURE STATEMENT
OWNERSHIP**

Provider Name, Provider No.: _____
Address (City, State, Zip): _____
Telephone _____

For the period beginning: _____ and ending _____ Type

of Provider:

- Staff — A Provider that delivers services through a group practice established to provide health services to Provider members; doctors are salaried,
- Group — A Provider that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.
- IPA — A Provider that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- Network — A Provider that contracts with two or more group practices to provide health services.

Type of Entity:

☐ Sole Proprietorship
☐ Partnership
☐ Corporation
☐ Governmental

☐ For-Profit
☐ Not-For-Profit
☐ Other (specify) _____
☐ _____

Annual Disclosure of Ownership (ADO) Instructions

FIELD #	DESCRIPTION
1	Enter name of individual or entity depending on who the ADO is in regards to.
2	Enter current NPI/Medicaid Provider number combination that this ADO is in reference to, if applicable.
3	If there has been a change of ownership or a Federal Tax Identification number, list previous Medicaid provider numbers and effective dates for each, if applicable.
4	Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C". a. Describe the relationship between the old owner and the new owner. Are they totally different owners or some of the owners the same, etc.? b. Describe the relationship between the old board members (under old owner) and the new board members (under the new owner). Are any of the board members under the old ownership also board members under the new ownership structure? c. Why is the old owner disenrolling? Essentially, why are there a change in ownership?
5	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
6	Do you anticipate filing bankruptcy? If so, when?
7	Enter the Federal Tax Identification Number (if there is an affiliation with a chain) along with name, address, city, state and zip code.
8	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. Complete question 9 with the officers' and board members' information of the owning entities. If no one owns 5% or more of provider, check box and completed question 9 with the officers' and board members' information. If you are enrolled as an individual and do not own a FEIN, please enter <u>your</u> name and information. Corporate entities disclosed in this question must disclose every business location.
<p>Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.</p> <p>Ownership Interest - means the possession of equity in the capital, the stock, or the profits of the disclosing entity.</p>	

<p><u>Person with an Ownership or Control Interest</u> - means a person or corporation that:</p> <ul style="list-style-type: none"> • Has an ownership interest totaling 5% or more in a disclosing entity; • Has an indirect ownership interest equal to 5% or more in a disclosing entity; • Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; • Is an officer or director of a disclosing entity that is organized as a corporation; or, • Is a partner in a disclosing entity that is organized as a partnership? 	
9	List officers' and board members' information of the owning entities. If no one owns 5% or more and/or the provider is non-profit, the officers' and board members' information must be disclosed.
10	If applicant is related to persons listed in #8 and 9, list the relationship.
11	List name of managing company, if not applicable enter N/A.
12	List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.
<p><u>Other Disclosing Entity</u> - means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:</p> <ul style="list-style-type: none"> • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII). • Any Medicare intermediary or carrier. • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health- related services for which it claims payment under any plan or program established under Title V or Title XX or the Act. 	
13	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of \$25,000 or 5% of applicant's operating expense, list subcontractor's name and address.
<p>Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5% of applicant's operating expense.</p>	
14	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period.
15	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
16	List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any HI Medicaid provider number(s) associated with individual or organization.

17	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any HI Medicaid provider number(s) associated with individuals or organization.
<p>Agent - means any person who has been delegated the authority to obligate or act on behalf of a provider.</p> <p>Managing Employee - means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.</p>	
18	List the name, title, FEIN/SSN, and business address of all managing employees as defined in 42 CFR 455.101.
19	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.
<p>Subcontractor - means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.</p>	
20	<p>Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. <i>Example: If you are an individual completing this question, please input your Social Security Number unless you own a FEIN 100%. An individual provider can bill under his/her individual provider number even if they are working in a group selling. The individual must complete a Map-347 in order to be linked to the group selling under which they are reporting.</i></p> <p>**IRS verification letter or Social Security Card must be attached verifying FEIN/SSN.</p>
21	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
22	Please enter the contact information for OMS to contact should there be any questions regarding this form.
23	<p>Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, <i>your</i> signature is required.</p> <p>Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed.</p> <p>Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc.</p>
24	For Internal Purposes Only: DMS Authorized Signature

Please return form to:

DHS Med-QUEST
Finance Office
P.O. Box 700190
Kapolei, HI 96709-0190

Annual Disclosure of Ownership (ADO)

THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and HAR §17-1736-19).

Note: See the instructions of this form for definitions of underlined terms according to 42 CFR 455.101, 455.104, 455.105, and HAR §17-1736-19. **All attachments must be labeled and reference to the question the attachment pertains.**

1	Entity Name that this ADO pertain to:			
2	Enter current NPI/Medicaid Provider number combination that this ADO is in reference to, if applicable. NPI: _____ Provider number: _____ Provider number (Enter only if you aren't required to have a NPI/Taxonomy Code for billing purposes): _____ <input type="checkbox"/> Check here for N/A			
3	If there has been a change in ownership, change of tax ID number (FEIN), or change in Medicaid Provider Number for a previously enrolled Hawaii Medicaid provider, enter the previous provider number(s) and their effective date(s): <input type="checkbox"/> Check here/or N/A			
	Previous Medicaid Prov. #:	Start Date:	End Date:	
4	If you completed #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and <u>ownership or control interest</u> (c) disenrollment circumstances. (Attach extra page if necessary.)			
a.				
b.				
c.				
5.	If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. <input type="checkbox"/> Check here for N/A			
	Date	Change		
6.	If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. <input type="checkbox"/> Check here for N/A			
7.	If this facility is a subsidiary of a parent corporation, enter corporate FEIN#:			
	<input type="checkbox"/> Check here for N/A			
	Name:			
	Address:			
	City:	State:	Zip Code:	

8.	List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or <u>indirect ownership</u> or controlling interest in the applicant provider. (Attach extra pages if necessary.) <i>Complete question 9 with the officer's and board members' information of the owning entities.</i>		
Name/Business Name:		SSN:	
Business Address:		FEIN:	DOB:
City:		State:	Zip:
** If a corporate entity is disclosed in question #8 above, all business location(s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.			
9.	List officers' and board members' information of owning entities. However, if no one owns 5% or more direct or indirect ownership, please list the officers' and board member's information. (Attach extra sheet if necessary listing same details below.) <input type="checkbox"/> Check here for N/A		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
10.	If any individuals listed in questions 8 and 9 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) <input type="checkbox"/> Check here for N/A		
Name (a):		SSN:	
Relationship:		FEIN:	
Name (b):		SSN:	
Relationship:		FEIN:	
11.	If this facility or organization employs a management company, please provide following information: <input type="checkbox"/> Check here for N/A		
Name:			
Address:			
City:		State:	Zip:
12.	List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. <input type="checkbox"/> Check here for N/A		
Name:		Provider #, if applicable:	
Address:			
City:		State:	Zip:
13.	List the names and addresses of all other Hawaii Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of \$25,000 or 5% of your total operating expense. (Attach extra page if necessary.) <input type="checkbox"/> Check here for N/A		
Name:			
Address:			
City:		State:	Zip:

14.	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) <input type="checkbox"/> Check here for N/A		
Name:			
Address:			
City:		State:	Zip:
15.	List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. <input type="checkbox"/> Check here for N/A		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
16.	List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) <input type="checkbox"/> Check here for N/A		
Name (a)/HI Medicaid Provider Number(s), if applicable:			
Name (b)/HI Medicaid Provider Number(s), if applicable:			
17.	List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), indicate below. (Attach extra page if necessary.) <input type="checkbox"/> Check here for N/A		
Name (a)/HI Medicaid Provider Number(s), if applicable:			
Name (b)/HI Medicaid Provider Number(s), if applicable:			
18.	List the name, title, FEIN/SSN, and business address of all managing employees below as defined in 42 CFR 455.101. <input type="checkbox"/> Check here for N/A (Attach extra page if necessary listing same details below.)		
Name(a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:
Name(b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip:

19.	List the name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) <input type="checkbox"/> Check here for N/A		
Name:		SSN:	
Address:		FEIN:	
City:	State:	Zip:	
Name:		SSN:	
Address:		FEIN:	
City:	State:	Zip:	
20.	Indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. _____		
21.	If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected. Every health care provider or organization, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation is a covered entity and must comply with HIPAA Privacy and Security Rules. Initials _____		
22.	<u>Contact Information</u> - This information is used only for questions regarding the information on this form.		
	Contact Name:	Contact Telephone:	
	E-mail address:		
23.	I certify that all the Information I have provided on this DHS, Med-QUEST Division Annual Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program.		
	Signature	Date Signed:	
	Printed Name:		
	Title:		
24.	For Internal Use Only:		
	Signature	Date Signed:	
	Printed Name:		
	Title:		
EPLS/SAM:		OIG/HHS:	SSA Death Master File:

[illegible][illegible]

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

- 1) If other than a government agency:
 - a. When was your organization formed?
 - b. If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.
- 2) License/Certification
 - a. Indicate all licenses and certifications (i.e., Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper using the following format:

<u>Service Component</u>	<u>License/Requirement</u>	<u>Renewal Date</u>
--------------------------	----------------------------	---------------------

- b. Have any licenses been denied, revoked, or suspended?

Yes _____ No _____ If yes, please explain:

- 3) Civil Rights Compliance Data

Has any Federal or State agency ever made a finding of noncompliance with any relevant civil rights requirements with respect to your program?

Yes _____ No _____ If yes, please explain:

- 4) Handicapped Assurance

Does your organization provide assurance that no qualified handicapped person will be denied benefits of or excluded from participation in a program or activity because the applicant's facilities (including subcontractors) are inaccessible to or unusable by handicapped persons? (note: check with local zoning ordinances for handicapped requirements)

Yes _____ If yes, briefly describe how such assurances are provided.

No _____ If no, briefly describe how your organization is taking affirmative steps to provide assurance.

- 5) Prior Convictions

List all felony convictions of any key personnel (i.e., Chief Executive Officer, Applicant's Manager, Financial Officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal as unresponsive.

- 6) Federal Government Suspension/Exclusion

Has applicant been suspended or excluded from any federal government programs for any reason?

Yes _____ No _____ If yes, please explain:

Financial Planning Form

- 1) Is the applicants accounting system based on a cash, accrual, or modified method?
- a. Cash ☐
 - b. Accrual ☐
 - c. Modified ☐ Give brief explanation

- 2) Does the applicant prepare an annual financial statement?

Yes _____ No _____ If yes, please explain:

- 3) Are interim financial statements prepared? Yes _____ No _____

a. If yes, how often are they prepared? _____

- b. If yes, are footnotes and supplementary schedules an integral part of the statements?

Yes _____ No _____

- c. If yes, are actuals analyzed and compared to budgeted amounts?

Yes _____ No _____

- d. If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

- 4) Is the applicant audited by an independent accounting firm/accountant?

Yes _____ No _____

a. If yes, how often are audits conducted? _____

b. By whom are they conducted? _____

- c. Did this auditor perform that applicant's last audit?

Yes _____ No _____

If no, provide the name, address, and telephone number of the firm that performed the applicant's last audit.

- d. Are management letters on internal controls issued by the accounting firm?

Yes _____ No _____

If yes, attach a copy of the management letter from the latest audit. This must be on the auditor's letterhead and the applicant, by its submission, certifies the letter is unaltered.

If no, the applicant shall provide a comprehensive description of internal control systems. The applicant is responsible for instituting adequate procedures against irregularities and improprieties and enforcing adherence to generally accepted accounting principles.

Yes _____ No _____

e. Do you have any uncorrected audit exceptions?

Yes _____ No _____

If yes, provide a copy of the auditor's management letter (see 4(d) of this form for instructions regarding submittal).

5) Does the applicant have an accounting manual?

Yes _____ No _____

If no, the applicant must explain, if it has proper accounting policies and procedures, and how it provides for the dissemination of such accounting policies and procedures within its organization and what controls exist to ensure the integrity of its financial information. The applicant agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

6) Does the applicant have a formal basis to allocate indirect costs reflected in your financial statement?

Yes _____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

7) What types of liability insurance does the applicant have?

a. With what company(s)? _____

b. What is the amount of coverage for each type of insurance? _____

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the applicant or its owner(s).

- 9) Are there any suits, judgments, tax deficiencies, or claims pending against the applicant?

Yes _____ No _____

Briefly describe each item and indicate probable amount.

- 10) Has the applicant or its owner(s) ever gone through bankruptcy?

Yes _____ No _____

If yes, when? _____

- 11) Do(es) the applicant's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?

Yes _____ No _____

If yes, describe the dollar amount(s) and source(s) of all funding.

If no, briefly describe how your organization is taking affirmative steps to provide funding.

- 12) Does the applicant have a performance bonding mechanism in accordance with DHS rules?

Yes _____ No _____

If yes, provide the following information:

Amount of Bond \$ _____

Term of Bond _____

Bonding Company _____

Restrictions on Bond _____

If no, describe how the applicant intends to provide a bond and/or security to meet established DHS rules.

- 13) Does the applicant have a financial management system to account for incurred, but not reported liabilities?

Yes _____ No _____

If no, the applicant must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's, the applicant, regardless of response (either yes or no) must complete items "a" through "h" below.

- a. Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes _____ No _____
- b. How often are IBNRs projected? _____
- c. Identify all major data sources most often used.
- d. Are data from open referrals and prior notifications used?
Yes _____ No _____ If so, how?
- e. Are detailed written procedures maintained? Yes _____ No _____
- f. Are IBNR amounts compared with actuals and adjusted when necessary?
Yes _____ No _____
- g. Is the basis of periodic IBNR estimates well documented?
Yes _____ No _____
- h. The applicant must provide a copy of IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the applicant is cautioned to provide additional data.

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the applicant will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system).

14) Does the applicant have a full-time (100%) controller or chief financial officer?

Yes _____ No _____ If yes, enter name: _____

15) Are the following items reported on the applicant's financial statements?

a. Medicare reimbursement Yes _____ No _____

b. Other third-party recoveries Yes _____ No _____

If no, explain why.

Controlling Interest Form

The applicant must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., ability to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the applicant's proposal as unresponsive.

Name	Address	Owner or Controller	Has Controlling Interest?	
			Yes	No

Background Check Information Form

The applicant must provide sufficient information concerning key personnel (i.e. Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to enable DHS to conduct background checks. Failure to make full and complete disclosure may result in rejection of your proposal as unresponsive. Attach resumes for all individuals listed below.

<u>Name**</u>	<u>Ever known by another</u> <u>Yes</u> <u>No</u>	<u>Social Security</u> <u>Account #</u>	<u>Date of Birth</u> <u>(Da/Mo/Yr)</u>	<u>Place of birth</u> <u>City/County/State</u>
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* If yes, provide all other names. Use a separate sheet if necessary.

** For each person listed:

- a. Give addresses for the last ten years
- b. Ever suspended from any Federal program for any reason?

Yes _____ No _____ If yes, please explain.

Operational Certification Submission Form

The applicant must complete the attached certification as documentation that it shall maintain member handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rules or policies and procedures.

By signing below the applicant certifies that it shall at all times during the term of this contract provide and maintain member handbook, appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The applicant warrants that in the event DHS discovers, through an operational review, that the applicant has failed to maintain these operating procedures, the applicant will be subject to a non-refundable, non-waiveable sanction in accordance with DHS rules.

Signature

Date

Grievance System Form

The applicant must complete the form below and submit with this proposal.

I hereby certify that _____

Applicant Name

will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and assure the participation of individuals with authority to require corrective action.

I further understand the applicant must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the applicant. The grievance policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance procedure shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by DHS and deficiencies are subject to sanction in accordance with DHS rules.

Authorized Signature

Date

Printed Name

Title

INSURANCE REQUIREMENTS CERTIFICATION

Proposals submitted in response to the RFP must include a Certificate of Liability Insurance (COLI) that meets the requirements of the RFP, summarized in the Checklist and sample Form Acord 25 attached hereto. The successful bidder will be required to provide an updated COLI upon contract award.

Time is of the essence in the execution and performance of the contract resulting from this RFP. Therefore, the Applicant must ensure that the COLI submitted with the proposal and, if applicable, the resulting contract, fully and timely complies with the insurance requirements of this RFP.

By signing below, the Applicant certifies that it has completed the attached Checklist and:

(Check and complete one)

- ☐ Applicant has included a current COLI with its proposal that fully meets the insurance coverage requirements contained in the RFP and in the attached Checklist.
- ☐ Applicant has included a current COLI with its proposal that meets the insurance coverage requirements contained in the RFP and in the attached Checklist and Form, *except for the following* (explain in detail):

If Applicant is awarded a contract, then Applicant certifies that the foregoing deficiencies will be corrected within five (5) business days after contract award.

Name of Applicant

Authorized Representative Signature

Date

Print Name and Title

**CERTIFICATE OF LIABILITY INSURANCE (COLI) CHECKLIST & SAMPLE FORM (ACORD 25
Form (2010/05)¹)**

This Checklist must accompany the completed COLI submitted with the proposal and subsequent contract. In the event of a conflict between this Checklist and the terms of the contract, the latter shall prevail.

If a requirement noted below is reflected in a current policy endorsement, a copy of the endorsement may be submitted in lieu of the statement on the COLI. Insurance requirements are subject to oversight by the State of Hawaii Department of Accounting and General Services, Risk Management Office.

NO. CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS

- (1) THE DATE THE COLI ISSUED SHOULD NOT BE MORE THAN 15 DAYS FROM THE DATE OF ITS REQUEST. THE COLI SHOULD NOT BE ISSUED OVER 30 DAYS FROM THE DATE OF SUBMISSION.
- (2) THE NAME OF THE "INSURED" MUST MATCH THE NAME OF THE CONTRACTOR/PROVIDER.
- (3) THE INSURER MUST BE LICENSED TO DO BUSINESS IN THE STATE OF HAWAII OR MEET THE REQUIREMENTS OF SECTION 431:8-301, HAWAII REVISED STATUTES.
- (4) THE "COMMERCIAL GENERAL LIABILITY" COVERAGE SHOULD INDICATE COVERAGE ON A "PER OCCURRENCE" BASIS.
- (5) A "POLICY NUMBER" OR BINDER NUMBER SHOULD BE INDICATED.
- (6) THE "EFFECTIVE DATE" SHOULD BE NO LATER THAN THE CONTRACT DATE OR THE FIRST DATE THAT THE CONTRACTOR COMMENCES WORK FOR THE STATE.
- (7) THE "EXPIRATION DATE" SHOULD BE AFTER THE EFFECTIVE DATE OF THE AGREEMENT OR SUPPLEMENTAL AGREEMENT, AS APPLICABLE, AND BE MONITORED TO ENSURE THAT RENEWAL COLI ARE RECEIVED ON A TIMELY BASIS.
- (8) THE LIMITS OF LIABILITY FOR THE FOLLOWING TYPES OF COVERAGE SHOULD BE FOR AT LEAST AS MUCH AS REQUIRED BY THE CONTRACT, NORMALLY IN THE FOLLOWING AMOUNTS (CHECK CONTRACT LANGUAGE FOR SPECIFICS):
 - A. COMMERCIAL GENERAL LIABILITY
\$1 MILLION PER OCCURRENCE, AND
\$2 MILLION IN THE AGGREGATE
 - B. AUTOMOBILE – MAY BE COMBINED SINGLE LIMIT:
BODILY INJURY: \$1 MILLION PER PERSON, \$1 MILLION PER ACCIDENT
PROPERTY DAMAGE: \$1 MILLION PER ACCIDENT
 - C. WORKERS COMPENSATION/EMPLOYERS LIABILITY
(E.L.) E.L. EACH ACCIDENT: \$1 MILLION
E.L. DISEASE: \$1 MILLION PER EMPLOYEE, \$1 MILLION POLICY LIMIT
E.L. \$1 MILLION AGGREGATE

¹ The Contractor should use the Acord form currently in use at the time of submission with the contract.

NO. CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS

D. PROFESSIONAL LIABILITY

\$1 MILLION PER CLAIM, AND

\$2 MILLION ANNUAL AGGREGATE

- (9) "ANY AUTO" COVERAGE IS REQUIRED, OR IF NOT MARKED, "HIRED AUTOS" AND "NON-OWNED AUTOS" SHOULD BE INDICATED. IF THERE ARE NO CORPORATE-OWNED AUTOS, THEN THE "HIRED & NON-OWNED AUTO" MAY BE ENDORSED TO THE COMMERCIAL GENERAL LIABILITY TO SATISFY THIS REQUIREMENT.
- (10) IF THE LIMITS OF LIABILITY SHOWN FOR GENERAL LIABILITY OR AUTOMOBILE LIABILITY ARE LESS THAN REQUIRED BY CONTRACT, THEN UMBRELLA LIABILITY WITH COMBINED LIMIT MAY SATISFY THE MINIMUM REQUIREMENT AND THE STATE LISTED AS "ADDITIONAL INSURED" ON THE UMBRELLA POLICY OR THE UMBRELLA POLICY IS NOTED AS "FOLLOW FORM" ON THE CERTIFICATE.
- (11) NOTE: THE STATE REQUIRES HIGHER LIMITS OF \$1 MILLION, AS COMPARED TO THE BASIC LIMITS REQUIRED BY STATE LAW REGARDING WORKERS COMPENSATION COVERAGE.
- (12) THE REQUIRED "PROFESSIONAL LIABILITY" COVERAGE SHOULD BE INDICATED IN THIS SECTION.
- (13) THE "ADDL INSR" BOX SHOULD BE CHECKED TO INDICATE THAT THE STATE IS AN ADDITIONAL INSURED UNDER THE POLICY(IES), OR NOTED IN THE DESCRIPTION OF OPERATION BOX AT THE BOTTOM OF THE FORM.
- (14) THE "CERTIFICATE HOLDER" SHOULD BE THE NAME AND ADDRESS OF THE DEPARTMENT OF HUMAN SERVICES/MED-QUEST DIVISION, 1001 KAMOKILA BOULEVARD, SUITE 317, KAPOLEI, HAWAII 96707
- (15) THE COLI SHOULD BE SIGNED BY THE INSURANCE AGENT OR AN INSURANCE COMPANY REPRESENTATIVE.

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES BOX: THIS SECTION SHOULD CONTAIN THE FOLLOWING LANGUAGE:

THE STATE OF HAWAII IS AN ADDITIONAL INSURED WITH RESPECT TO OPERATIONS PERFORMED FOR THE STATE OF HAWAII. ANY INSURANCE MAINTAINED BY THE STATE OF HAWAII SHALL APPLY IN EXCESS OF, AND NOT CONTRIBUTE WITH, INSURANCE PROVIDED BY THIS POLICY.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
	PHONE (A/C No. Ext):	FAX (A/C No.):
INSURED	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	
	INSURER A:	NAIC #
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSUR LTR	TYPE OF INSURANCE	ADDITIONAL INSURER	POLICY NUMBER	POLICY EFF. DATE (MM/DD/YYYY)	POLICY EXP. DATE (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY					EACH OCCURRENCE \$
	COMMERCIAL GENERAL LIABILITY					DAMAGE TO RENTED PREMISES (Ea occurrence) \$
	CLAIMS-MADE <input type="checkbox"/> OCCUR <input type="checkbox"/>					MED EXP (Any one person) \$
						PERSONAL & ADV INJURY \$
	GEN'L AGGREGATE LIMIT APPLIES PER:					GENERAL AGGREGATE \$
	<input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC					PRODUCTS - COM/POP AGG \$
	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ea accident) \$
	ANY AUTO					BODILY INJURY (Per person) \$
	ALL OWNED AUTOS					BODILY INJURY (Per accident) \$
	HIRED AUTOS					PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB					EACH OCCURRENCE \$
	EXCESS LIAB					AGGREGATE \$
	DED <input type="checkbox"/> RETENTION \$ <input type="checkbox"/>					\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY					WC STATUTORY LIMITS <input type="checkbox"/> OTHER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICEMEMBER EXCLUDED? (Mandatory in NH)	Y/N <input type="checkbox"/>	N/A <input type="checkbox"/>			E.L. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below					E.L. DISEASE - EA EMPLOYEE \$
						E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Wage Certification

Pursuant to Section 103-55, Hawaii Revised Statutes, I hereby certify that if awarded the contract In excess of \$25,000, the services to be performed will be performed under the following conditions:

1. The services to be rendered shall be performed by employees paid as wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.
2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

I understand that all payments required *by* Federal and State laws to be made by employers for the benefit of their employees are to be paid in addition to the base wages required by Section 103-55, HRS.

Applicant: _____
Signature: _____
Title: _____
Date: _____

**PROVIDER'S
STANDARDS OF CONDUCT DECLARATION**

For the purposes of this declaration:

“Agency” means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

“Controlling interest” means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

“Employee” means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of:

(Name of PROVIDER)

PROVIDER, the undersigned does declare as follows:

1. PROVIDER ☐ is* ☐ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. PROVIDER has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. PROVIDER has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. PROVIDER has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

PROVIDER understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawai'i Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the

* Reminder to agency: If the “is” block is checked and if the Contract involves goods or services of a value in excess of \$10,000, the Contract may not be awarded unless the agency posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

CONTRACT NO. _____

declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

Date _____